VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

November 28, 2011

Mr. James Thomsen, Administrator
Lodge At Otter Creek ALR
350 Lodge Road
Middlebury, VT 05753-4498

Provider #: 1008

Dear Mr. Thomsen:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **October 5, 2011.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

Division of Licensing and Protection

NOV 16 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1008	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LODGE AT OTTER CREEK	350 LODGE ROAD MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: A re-licensure survey was completed on 10/5/11 by the Division of Licensing and Protection. The survey also included investigation of 7 regulatory complaints. The following regulatory violations were found.	R100	Please see attached Plans of Correction (POC) for all citations.	
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, 2 of 9 residents in the total sample did not receive care to meet the residents' nursing and medical care needs after each had experienced a fall. (Residents #1 & #8) Findings include: 1. Per review of a progress note (dated 10/1/11 at 12:04), Resident #1 experienced a fall with injury on the morning of 10/1/11 and the shift nurse failed to document evidence that the physician was immediately notified after 911 was called for transport to the hospital Emergency Room for evaluation of injuries. The resident was diagnosed with a pelvic fracture which required a change in care provision due to decreased mobility function and increased pain symptoms. The nurse on duty failed to complete the incident report per facility policy and did not fill out the area for time and date of physician and family	R126		

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R126	Continued From page 1 notification after the resident's accidental fall. During interview at 1:00 PM on 10/4/11, the charge nurse confirmed that there was no evidence the resident's physician was notified timely and that she notified the provider on 10/3/11 when she returned to work. 2. Per record review on 10/5/11, there was no documentation of physician notification or follow-up actions after Resident #8 experienced a fall on 7/16/11 and had a subsequent rapid heart rate noted 2 days later. Review of a progress note of 7/16/11, revealed the resident had a fall at approximately 11:35 AM and stated that h/she "hit [his/her] head". There is no documentation of a nursing assessment immediately following the reported fall. There is a note written on 07/16/11 which was a carry over note from the Med Tech from the PRN administration of Tylenol for complaints of a headache. A note on 7/17/11 describes the resident as "not acting himself". A note written by the Unit Manager on 07/18/11 documents an assessment and records VS including a rapid pulse rate of 163 (tachycardia). There was no evidence in the record that the physician had been made aware of the rapid heart rate During interview on the afternoon of 10/05/11, the Unit Manager stated that it was expected that a nurse would do an assessment after a fall and document the findings and that vital signs would be monitored after a possible head injury. She also stated that in her assessment of 10/18/11, the resident's heart rate was above the normal range at 163 beats per minute but that the resident had exhibited an increased heart rate before during a pain episode. She acknowledged that she had assumed that the increased heart rate was due to pain and not a possible injury	R126		

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R126	Continued From page 2 from the fall. She further acknowledged that there was no evidence of reassessing the heart rate after administration of pain medication (Tylenol 650 mg) and warm compresses. She confirmed that the family was notified of the fall on 07/18/11 and that there was no evidence that the physician was notified of the fall and the rapid heart rate.	R126		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that medications were consistent with the physician's orders for 1 applicable resident in the sample. (Resident #7). Findings include: Per staff interview and record review, Resident #7 did not receive a psychoactive medication at the time ordered by the physician on 10/4/11. On 10/04/2011 at 1:45 PM the Medication Technician (MT) on the Haven Unit was overheard telling an arriving Home Health Aide (HHA) that "[Resident #7] just had her Haldol." Per review of the physician orders and medication administration record (MAR) the order for Haldol read 'Haldol 1 mg (milligram) PO (by mouth) AM and noon, 2 mg PO at HS (hour of sleep)'. Per staff interview and review of the MAR entry for 10/04/2011, the Haldol 1 mg PO was administered at 1:26 PM. The MT confirmed	R128		

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R128	Continued From page 3 during interview at 1:55 PM that s/he had failed to administer the medication at noon as ordered. The Unit Manager also confirmed during interview that all medications should be administered at the physician ordered time.	R128		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the nurse failed to assure that care plans addressed all of the resident's identified needs for 5 of 9 residents reviewed. (Residents #1, 3, 4, 5 & 6) Findings include: 1. Per record review on 10/4/11, Resident #1's care plan failed to address the resident's need for daily and PRN anti-anxiety medication to treat an anxiety disorder. The lack of a plan for these needs was confirmed during interview with the RN Charge Nurse at 1 PM the same day. 2. Per record review on 10/5/11, Resident #6's care plan failed to address the resident's respiratory status which requires daily "Combivent MDI 2 puffs QID (4 times daily) with aerochamber" and "Albuterol 2.5 mg/3 ml -- give 1/2 solution BID (2 times daily) PRN (as needed)". This resident had also experienced a	R145		

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R145	Continued From page 4 fall with a bone fracture in April 2011. There was no mention in the plan of care around temporary interventions to be initiated surrounding this resident's increased care needs. During interview on 10/5/11 at 10:55 AM, the HSD (Health Services Director) confirmed that the care plan did not address probable respiratory issues and that there was no indication that the care plan had been updated to include the resident's fracture and increased needs. 3. Per record review on 10/4/11, Resident #3's care plan failed to address the resident's needs regarding the diagnosis of Type II Diabetes requiring daily oral medication and a therapeutic diabetic diet which included no concentrated sweets. 4. a. Per record review on 10/4/11, Resident #4's care plan failed to address the resident's needs regarding a diagnosis of Type II Diabetes and that s/he has orders for an oral diabetic medication as well as for finger stick blood sugars (FSBS) to be checked on a daily basis. b. Resident #4's care plan failed to address needs regarding the diagnosis of hypertension, with fluctuations in his/her blood pressure(BP) and a physician's order to 'check BP and pulse and record BID' (twice a day). c. Resident #4's care plan failed to address needs regarding urinary retention and episodes of both bowel and urinary incontinence. The resident assessment completed on 4/18/11 stated, 'the resident is frequently incontinent of urine and is occasionally incontinent of stool.' 5. a. Per record review on 10/4/11, Resident #5's care plan failed to address the resident's needs regarding an anxiety disorder requiring anti-anxiety medication on a daily basis (as a	R145		

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R145	Continued From page 5 regularly scheduled dose) as well as PRN orders (take as necessary). The medication administration record (MAR) for the anti-anxiety medication that s/he were taking stated, 'try calming techniques first' (before administering the PRN dose) and those calming techniques/interventions were not included on the care plan. b. Resident #5 had a diagnosis of diabetes and diabetic neuropathy which included the use of special diabetic shoes that needed to be worn daily. The care plan did not include this intervention nor any others to address specific diabetic needs. c. Resident #5, who had a history of diverticulitis (bowel disease) with altered bowel elimination, had no care plan to address issues including rectal pain and episodic loose stools requiring PRN medications. The resident's bowel diversion appliance also required ongoing daily care and management by caregivers. d. Per review on 10/4/11, Resident #5's admission assessment dated 6/20/11 identified the resident as having 'moderately impaired vision'. The resident has a diagnosis of macular degeneration and wears glasses daily and there was no care plan to address these needs. Per interview on 10/4/11 at 1:30 PM with the Health Services Director (HSD) s/he confirmed that updating the careplans is a 'work in progress' and confirmed the above careplans for Residents # 3, #4 & #5 were not complete.	R145		
R147 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and	R147		

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R147	Continued From page 6 physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to maintain a list of each resident's medications that included; name, medications, date ordered, dosage and frequency of administration and likely side effects to monitor for 2 applicable residents in the sample. (Resident #1 & #6) Findings include: 1. Per record review on 10/4/11 and confirmed by RN interview at 10 AM, there was no complete list maintained in Resident #1's medical record that included all medications ordered, date ordered, dosage and frequency of administration and side effects to monitor. In addition, the RN failed to note that 2 current physician orders for PRN (as needed) pain medication and anti-anxiety medication failed to specify a maximum daily dose for each medication and if given as ordered, could result in excessive doses with significant adverse effects to the resident. The orders included:" lorazepam intensol 0.5 mg/0.25 ml, PO anxiety/restlessness, if single dose not effective, contact nurse for additional administration, maximum dose 2.0 mg PO Q 30 minutes as needed." The other order stated:" Roxanol intensol 5 - 20 mg. PO Q 15 minutes PRN pain or breathlessness." During interview on 10/4/11 at 10 AM, the RN agreed that the order failed to include a maximum daily dose that would eliminate the potential for administration of an excessive dose. Refer also to R167	R147		

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R147	Continued From page 7 2. Per record review on 10/5/11, Resident #6's MAR (Medication Administration Record) contained an order for "Ocuvite Preservision 1 BID" , "Combivent MDI 2 puffs QID (4 times daily) with aerochamber" and "Albuterol 2.5 mg/3 ml give 1/2 solution BID PRN (as needed)". These written orders were consistent with the signed physician orders (8/11/11). The Ocuvite had no prescription strength and the Combivent and Albuterol had no identified diagnosis for use. During interview on 10/5/11 at 9:15 AM, the HSD (Health Services Director) confirmed that these orders were incomplete and should be verified with the prescribing physician.	R147		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	R167		

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R167	Continued From page 8 facility failed to assure that staff other than a nurse administered PRN psychoactive medications in accordance with a specific plan that included all of the required elements as specified in 5.10.d for 1 applicable resident in the sample. (Resident #1) Findings include: Per record review on 10/4/11, Resident #1 had physician orders for PRN (as needed) Lorazepam to be given for anxiety/restlessness. Per review of the electronic PRN Medication Administration Record (MAR) with the RN at 1:30 P.M., there was no plan that identified the specific behaviors the medication was intended to treat, the circumstances that indicate the use of the medication, and educated staff about desired effects and potential adverse side effects to monitor for. The RN confirmed that the MAR documentation did not meet these requirements. Refer also to R 147.	R167		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication,	R171		

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R171	Continued From page 9 and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the nurse failed to assure that 1 applicable resident was appropriately monitored for the undesired side effects of a newly ordered antipsychotic medication. (Resident #6) Findings include: Per record review on 10/5/11, Resident #6 had physician orders dated 9/28/11 for 'Haldol 2 mg (milligrams) by mouth QHS' (every evening at bedtime). There was no evidence in the medical record that a baseline screening assessment was completed upon initiation of this medication. During interview on 10/5/11 at 10:55 AM, the HSD (Health Services Director) confirmed that the resident had begun taking Haldol and has not had a baseline screening assessment for use in monitoring the potential future side effects of this medication.	R171		
R181 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for	R181		

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R181	Continued From page 10 actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the licensee failed to assure that a contracted person with a criminal conviction record was not employed at the facility. Findings include: Per record review on 10/4/11, there was no background check information available for surveyor review regarding a former contracted employee who was the subject of a complaint investigation. Per interview on 10/4/11 with the ALR (Assisted Living Residence) Administrator and the RCH (Residential Care Home) Manager, an employee hired through another company owned by the licensee had a known felony conviction background shortly after beginning job duties at the home. Per this interview, the licensee was aware of this conviction history and when discussion around feasibility of retaining the employee was initiated by the Administrative team, the licensee insisted that the employee be retained. This employee worked for approximately 6 months with daily access to all residents and their living areas from	R181		

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R181	Continued From page 11 approximately June 2010 to January 2011.	R181		
R192 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.d Reports and records shall be filed and stored in an orderly manner so that they are readily available for reference. Resident records shall be kept on file at least seven (7) years after the date of either the discharge or death of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to retain records and reports in an orderly fashion to make them available for reference. Findings include: 1. Per record reviews on 10/4/11 and 10/5/11, the results of three reported potential narcotic diversion investigations were not available for surveyor review. During interviews with the Administrator and the former Health Services Director on 10/4/11 and 10/5/11, these records were not available. 2. Per record reviews on 10/4/11 and 10/5/11, the personnel record of a formerly contracted employee was not available on site. A request for this information from the corporate offices was made on 10/4/11 and 10/5/11, however the records were not provided for surveyor review. The Administrator confirmed on the afternoon of 10/5/11 that these records were unavailable.	R192		

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R220	Continued From page 12	R220		
R220 SS=C	VI. RESIDENTS' RIGHTS 6.7 A resident may complain or voice a grievance without interference, coercion or reprisal. Each home shall establish a written grievance procedure for resolving residents' concerns or complaints that is explained to residents at the time of admission. The grievance procedure shall include at a minimum, time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint will be made aware of the Office of the Long Term Care Ombudsman and Vermont Protection and Advocacy as an alternative or in addition to the home's grievance mechanism. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to include all of the Vermont State required components in it's Resident Grievance Policy/Procedure. Findings include: Per review on 10/5/11, the facility's Policy/Procedure for a Resident Grievance failed to include the requirement to state the method to contact the Office of the Long Term Care Ombudsman and Disabilities Rights Vermont, as an alternative to, or, in addition to the home's grievance mechanism. The lack of the required language was confirmed during interview with the Administrator at 2:30 PM on 10/5/11.	R220		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation	R247		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247	Continued From page 13 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all perishable foods were labeled and/or dated and discarded after the maximum safe storage time, per facility policy and accepted safe food handling practices. Findings include: Per observation during a kitchen tour conducted on 10/04/2011 at 10:20 AM accompanied by the Dietary Manager the following issues were identified: a. In the walk-in cooler several containers were observed to be outdated, undated or unlabeled. Foods observed included outdated-Primavera Sauce (9/26), Roast Beef (9/26), Turkey (9/28), Chocolate Ganache (8/18), Apple Pie Filling (6/23) and Caramel Sauce(11/06). b. Undated items included Lime Vinaigrette, and undated/unlabeled (no dates or identifiers) items included Graham Cracker Crumbs, Bread Crumbs, and Roasted Red Pepper Sauce. The foods were removed and the findings were confirmed by the Dietary Manager on 10/04/2011 at the time of the walk-through of the cooler (10:20 AM).	R247		
R291 SS=E	IX. PHYSICAL PLANT	R291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1008	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LODGE AT OTTER CREEK	350 LODGE ROAD MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R291	Continued From page 14 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the home failed to assure that hot water temperatures were maintained at or below 120 degrees Fahrenheit (F.). Findings include: Per observation and temperature monitoring with the Shores Administrative Assistant on 10/5/11, the hot water temperatures in the bathroom off of room 240 was 120.9 degrees Fahrenheit (F.) at 10:20 AM, the Shores public area bathroom was 116.8 degrees F at 10:18 AM, and the Shores public bathroom near the library / dining room areas was 122.5 degrees F at 10:27 AM. Additional temperature monitoring was conducted with the Maintenance Director in rooms #205, #307 and #318 with temperature findings of 118.8 DF, 118.8 DF, and 122.3 DF respectively. The resident in room #318 stated "it gets very hot. . . you have to be careful". Per interview, the Maintenance Director stated that all temperature monitoring is done at the boiler gauge in the basement and that there is not a systematic resident area monitoring system in place to assure that water at the resident access areas is not too hot (does not exceed 120 degrees F.). S/he confirmed that this day's water temperatures were greater than 120 degrees F. in certain areas of the Shores residences.	R291		

TLOC plan of correction

R126

Deficiency #1

5.5 general care: 5.5a Upon a residents admission to a residential care home, necessary services shall be provided or arranged to meet the residents personal, psychosocial, nursing and medical care needs.

Deficiency: "Based on staff interview and record review 2 of 9 residents in the total sample did not receive care to meet the residents nursing and medical care needs after each had experienced a fall"

#1 **Action to correct deficiency:**

The lodge at Otter Creek policy will be updated to change our incident response system to utilize an EMR program called Point Click Care and there incident documentation which allows for clear, accurate and timely communication of incidents. All of our physicians will be asked for a standing order to call 911 if any resident experiences an acute injury or illness that could not be managed in a home environment.

The Point Care Click software program allows for immediate documentation if an incident, including description of incident, immediate actions, report of injuries, witnesses, documentation of notification of family and MD, and follow up care plan review or addition and nursing progress notes.

Expected implementation and education completed 11/15/11

#2 **Measures to assure that this does not recur:**

Every incident logged in to the Point Click Care system will be monitored for completion, accuracy, and utilized as QI monitoring tool. Re-education to all nursing staff to the importance of documentation incidents to the resident, physicians and family was completed at the 10/28/11 nursing staff

#3 **How corrective action will be monitored:**

Every incident logged in to the Point Click Care system will be monitored for completion, accuracy, and utilized as QI monitoring tool. The Point Click care system automatically logs and tracks incident's and he information around the incident. It has spreadsheet and data management tools that allows the DHS to extract data from these incidents to analyze for trends and put measures in place to prevent incidents from occurring as well as tracking that residents are care planed if an incident occurs

11/16/11 This will be monitored by the DHS and reported to the Regional DHS

R 128

Deficiency #2

5.5 General care 5.5c Each residents medication, treatment, and dietary services shall be consistent with the Physicians orders

Deficiency: "Based on staff interview and record review the facility failed to assure that medications were consistent with the physician orders for 1 applicable resident in the sample."

#1 **Action to correct deficiency:**

Primary nurses will be responsible for monitoring the timeliness of the med pass throughout the shift on their PCC dashboard, pulling 3 random reports weekly off of Point Click Care monitoring the timeliness and accuracy of the Medication Tech delivery of Medications, Treatments, and dietary orders. Any deviation from regulation or physician will be reported as a medication error and retraining and or disciplinary action will be completed. Medication error repots will be monitored and trends and deviations will be reported and acted upon in QI committee quarterly and Management meeting as needed.

#2 **Measures to assure that this does not recur:**

Any deviation from regulation or physician will be reported as a medication error and retraining and or disciplinary action will be completed. Medication error repots will be monitored and trends and deviations will be reported and acted upon in QI committee quarterly and Management meeting as needed. All med errors have been re-educated during the 10/25/11 med tech meeting.

Expected completion date November 1st 2011.

#3**How corrective action will be monitored:**

Primary nurses will be responsible for pulling 3 random reports weekly off of Point Click Care monitoring the timeliness and accuracy of the Medication Tech delivery of Medications, Treatments, and dietary orders. Any deviation from regulation or physician will be reported as a medication error and retraining and or disciplinary action will be completed. Medication error repots will be monitored and trends and deviations will be reported and acted upon in QI committee quarterly and Management meeting as needed.

11/16/11 This will be monitored by the DHS and reported to the Regional DHS

R145

Deficiency #3

5.9c Resident care and home services; Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the residential assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being.

Deficiency: "Based on staff interview and record review, the nurse failed to assure that the care plans addressed all of the residents needs for 5 of 9 residents reviewed."

#1 **Action to correct deficiency**;

The lodge at Otter Creek Has recently implemented a new nursing model incorporating primary nursing. Each nurse is responsible for monthly review of weights, vital signs, medication, care plans, health and wellness status and changes in ADL's. The Primary nurse is also responsible for quarterly standard assessments and annual or significant change residential assessments. Along with this new model implementation and education of the primary nurse model and expectations of the care plan. All the care plans have been reviewed and updated to describe the care and services necessary to assist the residents to maintain independence and well-being.

Expected completion date 11/1/11

#2 **Measures to assure that this does not recur**:

With regular monthly review and monitoring of health and wellness condition and incidents of residents in an updated EMR system there will be improved flow and coordination of the care plan from the caregiver to the primary nurse and monitoring by the Director of Health services.

#3 **How corrective action will be monitored:**

Two random charts from each nurse will be reviewed by the Director of Health Services and/or Regional Director of Health Services monthly for review and reported to the QI committee and immediate reeducation and/or disciplinary action will be completed for deficiencies.

R147

Deficiency #4

5.9c (4) Resident care and Home service; maintain a current list for review by staff and physician of all residents medications. The list shall include residents name, medications, date medication ordered, dosage and frequency of administration, and likely side effects to monitor.

Deficiency:" Based on staff interview and record review the RN failed to maintain a list of each resident's medications that included:" name, medications, date ordered, dosage, and frequency of administration and likely side effects to monitor for 2 applicable residents.

#1 **Action to correct deficiency**:

Under the Lodge at Otter Creek new primary nurse model with regular monthly and quarterly review of resident charts and accompanying education on expectations. Medication will also continue to be checked by a second nurse for completeness of the orders. All Physician orders and diagnosis have been added to all residents charts and reviewed for completeness and accuracy.

Expected completion date 11/1/11

#2 **Measures to assure that this does not recur**:

With regular review by a second nurse with further education of the expectations of ensuring maximum daily dose for the same medication or type of medication and updating of the medication library in our EMR system which includes the concentration of medications to prevent confusion and ensure completeness and accuracy.

11/16/11 The Primary nurse form each unit will monitor each chart for completeness and accuracy of Medications, treatments, diagnosis's, assessments and careplans

#3 **How corrective action will be monitored:**

Two random charts from each nurse will be reviewed by the Director of Health Services and/or Regional Director of Health Services monthly for review and reported to the QI committee and immediate reeducation and/or disciplinary action will be completed for deficiencies.

R167

Deficiency #5

5.10 Resident care and home services: Medication management

5.10.d If a resident requires medication administration, unlicensed staff may administer under certain conditions:

Deficiency: "Based on staff interview and record review, the facility failed to assure that staff other than a nurse administered PRN psychoactive medications in accordance with a specific plan that included all of the required elements as specified for 1 applicable resident in the sample.

#1 **Action to correct deficiency**:

Design and implementation of new PRN psychoactive PRN documentation with specific behavioral intervention prior to medication administration ensuring documentation for every resident receiving a PRN psychoactive medication and monitoring for potential adverse side effects. Re-education of all med techs as to required documentation of PRN and psychoactive medication occurred at 10/25 med tech meeting and initiation of new documentation of PRN psychoactive instituted

Expected completion date 11/1/11

#2 **Measures to assure that this does not recur**:

Continued on next page

#3 **How corrective action will be monitored:**

Two random charts from each nurse will be reviewed by the Director of Health Services and/or Regional Director of Health Services monthly for review and reported to the QI committee and immediate re-education and/or disciplinary action will be completed for deficiencies.

R167

Deficiency #5

5.10 Resident care and home services: Medication management

See amended P.O.C. on previous page.

5.10.d If a resident requires medication administration, unlicensed staff may administer under certain conditions:

Deficiency: "Based on staff interview and record review, the facility failed to assure that staff other than a nurse administered PRN psychoactive medications in accordance with a specific plan that included all of the required elements as specified for 1 applicable resident in the sample.

#1 **Action to correct deficiency**:

Design and implementation of new PRN psychoactive PRN documentation with specific behavioral intervention prior to medication administration ensuring documentation for every resident receiving a PRN psychoactive medication and monitoring for potential adverse side effects. Re-education of all med techs as to required documentation of PRN and psychoactive medication occurred at 10/23/11 med tech meeting and initiation of new documentation of PRN psychoactive instituted

Expected completion date 11/1/11

R167 Continued

#2 **Measures to assure that this does not recur**:

The nurse assigned to the unit each day will review PRN medication administration and ensure proper behavioral intervention prior to and documentation of potential adverse side effects or desired effects after administration.

#3 **How corrective action will be monitored:**

All PRN psychoactive forms will be tracked and monitored by the Director of Health Services or designee and reported to QI committee.

R171

Deficiency #6

5.10 Resident care and home services: Medication management

5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, RN, certified manager or representatives of the licensing agency that the medication regime as ordered is appropriate and effective.

Deficiency; " Based on interview and record review the nurse failed to ensure that 1 applicable resident was appropriately monitored for the undesired side effect of a newly ordered antipsychotic medication."

#1 **Action to correct deficiency**:

The 1 resident AIMS assessment was completed immediately and chart review concluded no further deficiencies for AIMs assessments for psychoactive.

Expected completion date 10/5/11

#2 **Measures to assure that this does not recur**:

The Lodge at Otter Creek has recently implemented a new nursing model incorporating primary nursing. Each nurse is responsible for monthly review of weights, vital signs, medication, care plans, health and wellness status and changes in ADL's. The Primary nurse is also responsible for standard assessments including AIMs at baseline, one month, with dose change, discontinue of psychoactive or at least quarterly and annual or significant change residential assessments. Along with this new model implementation and education of the primary nurse model and expectations of the care plan.

#3 **How corrective action will be monitored:**

Two random charts with psychoactive medications from each nurse will be reviewed by the Director of Health Services and/or Regional Director of Health Services monthly for review and reported to the QI committee and immediate re-education and/or disciplinary action will be completed for deficiencies.

R181

Deficiency #7

5.11 Resident care and home services

Staff services

5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her.

#1 **Actions to correct this deficiency:**

Every staff including hired and contracted staff with have a mandatory background check prior to being allowed to work individually in or around any residence at The Lodge at Otter Creek.

#2 **Measures to assure that this does not recur:**

This is Mandatory Policy at the Lodge at Otter Creek that The Lodge at Otter Creek will not employ any staff who has had a charge of abuse, neglect, or exploitation substantiated against him or her as defined in 33 V.S.A. chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont .

#3 **How corrective action will be monitored:**

The Executive Director's administrative assistant will monitor all new hire documentation and start dates to ensure background checks have been completed.

R 192

Deficiency #8

5.12 Records/Reports

5.12.d reports and records shall be filed and stored in an orderly manner so that they are readily available for reference.

Deficiency;"Based on staff interview and record review the home failed to retain records in an orderly fashion to make them available for reference"

#1 **Actions to correct this deficiency.**

Any available records on the resident incident and the personnel file have been compiled for review but are incomplete

#2 **Measures to assure that this does not recur:**

As per The Lodge at Otter Creek policy all personnel records and incident reports will be securely secured and stored by the Executive Director's administrative assistant for a period of not less than 7 (seven) years.

#3 **How corrective action will be monitored**

Periodic review by the Executive Director and his assistant will ensure that all records are accessible as required by regulation

R220

Deficiency #9

6.7 Residents rights: A resident may complain or voice a grievance without interference, coercion or reprisal. Each home shall establish a written grievance procedure for resolving residents' concerns or complaints that is explained to residents at the time of admission.

Deficiency" Based on record review and staff interview the facility failed to include all the Vermont State required components in it's Resident Grievance Policy/Procedure"

#1 **Actions to correct this deficiency:**

All Resident Grievance Policy documents and postings have been updated to include the method to contact the Office or the Long Term Care Ombudsman and Disabilities Rights Vermont as an alternative to the Lodge at Otter Creek grievance mechanism.

#2 **Measures to assure that this does not recur:**

All master copies of grievance documents have been modified

#3 **How corrective action will be monitored:**

All grievance documentation or postings will be from the Office of the Executive Director for monitoring for compliance and if updating of contact information is required.

R247

Deficiency #10

(see accompanying sheet labeled Division of Licensing and Protection sheet 14 of 15)

R291

Deficiency #11

IX. PHYSICAL PLANT

9.6 Plumbing

9.6.d Hot water shall not exceed 120 degrees Fahrenheit in resident areas.

To meet this requirement The Maintenance Director contacted VHV October 15th, 2011. A service technician was dispatched the following day. The hot/cold water mixing valve was adjusted at the hot water storage tanks located in the boiler room. A weekly testing policy is now in place and will be recorded as such by a member of the maintenance staff as overseen by the Maintenance Director. Records are available in the office of the Maintenance Director.

Readings were then taken at all locations observed by the State Licensing Inspector. The maximum reading is now 119 degrees Fahrenheit in the Shores public bathroom where the highest reading was taken during the previous inspection.

R126, R128, R145, R147, R167, R171, R181, R192, R220, R247, R291
Plans of Correction accepted 11/17/11 M. Bolton RN/ PM Cota RN